VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
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February 10, 2012

Ms. Lauri Brown, Administrator
Shelburne Bay Senior Living Community
185 Pine Haven Shore Road
Shelburne, VT 05482

Provider #: 0589

Dear Ms. Brown:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **January 4, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

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Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0589	A. BUILDING _____ B. WING _____	C 01/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBURNE BAY SENIOR LIVING COMMUNIT	185 PINE HAVEN SHORE ROAD SHELBURNE, VT 05482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced licensing survey and complaint investigation was conducted on 01/03/2012 and 01/04/2012 by the Division of Licensing and Protection. During the survey regulatory violations were identified relating to the survey. There were no violations resulting from the complaint investigation.	R100		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that the Plan of Care was revised, based on the resident assessment, to reflect the resident's current care needs for 1 applicable resident (Resident #1). Findings include: Per record review, Resident #1 was admitted to the hospital on 11/15/2011. A Change of Condition Assessment was conducted on 11/15/2011. The resident was re-admitted to the facility on 11/18/2011 and was placed on Hospice care. The care plan was not revised to include Hospice services nor did it reflect changes in resident oxygenation (with a plan for reduction of oxygen administration). The above information was confirmed in an interview with the Unit	R145		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

RN SENIOR DIRECTOR of HOME HEALTH SERVICES

Division of Licensing and Protection

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R145	Continued From page 1 Coordinator and the Healthcare Services Director-LPN on 01/04/12 at 12:50 PM.	R145		
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that at least 12 hours of staff inservice, including the 7 mandatory trainings, were attained by all staff providing direct care to residents. Findings include:	R179		

Division of Licensing and Protection

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R179	Continued From page 2 Per record review for 5 staff reviewed, for the calendar year of 2011, only two of the staff reviewed attained 11 hours of education which included all seven of the mandatory inservices. The remaining staff reviewed attained 8 hours of education but the inservices did not include all seven mandatory topics. The staff were missing one, two or three of the mandatory inservices respectively. The above information was confirmed with the Administrative Assistant responsible for tracking inservice trainings and the Healthcare Director-RN in interviews at 3:35 PM on 01/04/2012	R179		

Plan of correction for Shelburne Bay Senior Living

Licensing survey and complaint investigation completed 1/03/2012 and 1/04/12.

R145 V. RESIDENT CARE AND HOME SERVICES

5.9.c (2)

Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well being.

The REQUIRMENT is not met as evidenced by:

Based on record review, Resident #1 was admitted to the hospital on 11/15/2011. A Change of Condition Assessment was conducted on 11/15/2011. The resident was re admitted to the facility on 11/18/11 and placed on hospice care. The care plan was not revised to include Hospice services, nor did it reflect changes in resident oxygenation (with a plan for reduction of oxygen administration). The above information was confirmed in an interview with the Unit Coordinator and Healthcare Services Director - LPN on 1/04/12 at 12:50PM.

What action will be take to correct the deficiency:

Resident # 1 care plan was reviewed immediately. At the time of this survey this resident had previously been removed from Hospice and O2 support. Care plan was reviewed for any needed additions, none were determined.

What Measures will be put in place or what systemic changes will be made to assure that the deficient practice does not recur:

R145 -

Attached, you will find a new form which will be utilized for all residents being readmitted to SBSLC following a 3+ day stay at the hospital. This form will identify any changes to ADLs and will flag the nurse to question whether or not a change must be made to the care plan as well as a significant change assessment, if necessary. This form has been given to the nurses and will immediately be part of the readmission process.

All Nurses have been instructed in the development of care plans as this relates to Hospice services and O2 use.

How Corrective action will be monitored so the deficient practice does not recur:

The Health Services Director and The Senior Director of Health Services will perform Monthly audits to monitor for compliance.

R145 POC accepted 2/8/12 Annotated

R179 V. RESIDENT CARE AND HOME SERVICES

5.11 Staff Services

5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least (12) hours of training each year for each staff person providing direct care to residents.

This REQUIREMENT was not met as evidenced by:

Based on record review and staff interviews the facility failed to assure that at least 12 hours of staff in service, including the 7 mandatory training, were attained by all staff providing direct care to residents. Finding include: Per record review for 5 staff for the calendar year 2011, only two of the staff reviewed attained 11 hours of education which included all seven of the mandatory in services. The remaining staff reviewed attained 8 hours of education but the in services did not include all seven mandatory topics. The staff were missing one two and three of the mandatory in services respectively. the above information was confirmed with the Administrative Assistant responsible for tracking in service trainings and the Healthcare Director - RN in interviews at 3:35 PM on 01/04/2012.

What action will be take to correct the deficiency:

R179

All employees are required to come up to date on any outstanding 2011 educational requirements. The expectation is that all outstanding 2011 education requirements will be met by 2/28/12 or the employee will be removed form the schedule.

What Measures will be put in place or what systemic changes will be made to assure that the deficient practice does not recur:

Education will be monitored by the HSD and any staff that are non compliant with completion of monthly in service will be counseled accordingly. Those employee who do not attend monthly in

services / education will have 30 day to complete the self study and provide evidence of knowledge on the monthly topic, via test, which will be filed in that employees education file. The yearly in service / education schedule will include a 12 monthly topics, to include 7 mandatory topics. Please see attached policy.

R179 POC accepted 2/8/12 RNcotaRN